MOTT COMMUNITY COLLEGE
FLEXIBLE SPENDING ACCOUNT PLAN
REQUEST FOR REIMBURSEMENT FORM

(Please Print Clearly or Type)

Name_______________________________________ Social Security Number___________________________

Home Address_______________________ City_______________ State__________ Zip____________

Company Name __________________________                       Work Phone Number_____________________

THIS FORM MAY BE USED FOR EITHER HEALTH CARE REIMBURSEMENT ACCOUNT OR
DEPENDENT CARE REIMBURSEMENT ACCOUNT REQUESTS FOR REIMBURSEMENT.

--- HEALTH CARE REIMBURSEMENT ACCOUNT ---

Please indicate, within each particular category, the amount requested for reimbursement. Attach copies of
bills and any explanation of benefit forms reflecting insurance payments, and mail to: FlexSave of America, Inc.
28104 Orchard Lake Road, Suite #140, Farmington Hills, Michigan 48334. Fax: 248-539-8002

MEDICAL $___________________   VISION $________________
DENTAL $___________________   DEPENDENT CARE $  _______

--- DEPENDENT CARE REIMBURSEMENT ACCOUNT ---

Attach to this form a receipt for services rendered or statement of expenses and mail to: FlexSave of America,
Inc. 28104 Orchard Lake Road, Suite #140, Farmington Hills, Michigan 48334. Fax: 248-539-8002

Name of Dependent(s)__________________________
Relationship______________________________

Name of Provider_____________________________ Provider’s Taxpayer ID or SS#_____________________

Dates Care Provided: From_________________________ To_____________________________________

I request reimbursement from my account. I certify that the information provided is true and correct, that
these expenses are not and will not be covered by any insurance program, that I have not or will not claim these
expenses as income tax deductions on my income tax return, and that the expenses submitted qualify as
required. I also understand that the Internal Revenue Service may require proof that these are eligible
expenses, and that I am responsible for providing such proof.

Total Amount Submitted: $________________

Signature___________________________________ Date___________________________________________